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ABSTRACT

Included in this annotated bibliography on health education are journal articles, monographs, and government reports. Topics covered are patient education, community health education, school health education, sex education, lifestyle, general health education, research and evaluation, smoking, self-care, and other miscellaneous areas. It contains citations from 1977 and 1978 only. (DS)

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CURRENT AWARENESS IN HEALTH EDUCATION

Introduction

As interest in health education continues to develop and expand, there is a need for information resources to keep abreast of the growing body of formal literature, papers, research reports, conference proceedings, and dissertations which are being generated. Now, as in other fields, serial publications devoted entirely to health education and related topics are published.

Beginning with this issue, the Bureau of Health Education staff will extract health education items from publications and other data sources. The annotation following the citation is a direct excerpt from the published work and is not an abstract prepared by the Bureau of Health Education. This listing will be published as a current awareness service and will include journal articles, monographs, conference proceedings, reports, and non-published items selectively acquired. Since timeliness is desired, this publication will only contain citations of documents published in 1977, 1978, and subsequent years. Documents from previous years will be acquired to be published in a special issue.

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Each item accessioned will have a unique number indicating the calendar year it was processed, i.e., 78-0001 represents the year 1978 and the first document processed. Subject categories will be revised and changed as needed. By necessity, these categories will be broad, but as terms become more specialized, they will be redefined accordingly. The format will be alphabetical order by first author's last name within each subject category resulting in numerical order by accession number.

All persons receiving "Current Awareness in Health Education" are invited to contribute items for possible inclusion in the collection. Comments regarding this service are welcome.

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PATIENT EDUCATION

78-0001 Clarke, W.D.; Devine, M.; Jolly, B.C.; Meyrick, R.Ll.
Health education, with a display machine, in the surgery. Health Education Journal 36(4): 100-113, 1977.

The work described here is a sequel to a project reported in the Health Education Journal (vol. 35, no. 1, 1976), which described the use of cassette tapes, replayed over telephones, to promote health education in a doctor's waiting room.

78-0002 Lazes, P.M.; Wasilewski, Y.; Redd, J.D.
Improving out-patient care through participation. International Journal of Health Education 20(1):61-70, 1977.

As in most urban out-patient hospital settings, Martland Hospital in Newark, New Jersey, was plagued with inadequate communication and limited interaction between staff and patients. These problems were reflected in unnecessary patient revisits to the out-patient department, needless duplication of laboratory work, extensive waiting room delays, and an unawareness by many patients of their health problems and how to control or monitor them. These circumstances led to poor quality care and consequently actively discouraged patients from using the services. Staff felt no motivation for working in this setting. In order to resolve some of these problems, the Health Education Project of the College of Medicine and Dentistry of New Jersey began to work in April 1973 with patients and staff of the out-patient department on developing a positive environment for patients.

78-0003 Lee, E.A.; Garvey, J.L.
How is inpatient education being managed? Hospitals 51:75-82, Jun.1, 1977.

78-0004 National Symposium on Patient Education
Proceedings of the National Symposium on Patient Education. San Francisco, Sep. 24-25, 1977. U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, 1978, 119 pp.

The proceedings of the National Symposium on Patient Education represent the contributions of faculty speakers, presenters, and panelists to a 2-day program in San Francisco, California, on

September 24 and 25, 1977. Seven hundred participants came from nearly every state, Canada, and Puerto Rico. The objectives of the Symposium were: (1) To bring researchers, practitioners, students of patient education, health care administrators, and patients together to exchange ideas, data, and resources; (2) To explore how patient education has or can improve the health of the patient; (3) To identify and examine effective, well-planned patient education programs that are integral parts of health care delivery in inpatient and outpatient settings, community clinics, practitioners' offices, or extended care facilities; (4) To assist each participant to discover a new idea, resource, methodology, or research topic for application to the work, practice, or study of patient education; and (5) To study the feasibility of developing regional support groups, complemented by a national communique to promote the ongoing exchange of ideas, data, and resources in patient education.

78-0005 Porter, S.F.
Diabetic education: a role for the inservice instructor. Supervisor Nurse 8(5): 49-53, May 1977.

The lack of an effective patient education program becomes most obvious for those conditions which require that the patient participate in the therapeutic regimen for maintenance of health. Diabetes mellitus is such a condition. It requires the patient to manage a complex therapeutic regimen on a daily basis if he is to remain healthy and avoid the immediate and long-range complications of this disease. The effect that the absence of a comprehensive, organized patient education program has on the diabetic population of our community was substantiated by the professional experiences of a local diabetologist and by a nursing audit in our own agency. The purpose of this article is to discuss the process which was used by a city hospital to participate in a community patient education program, and to demonstrate the role of the inservice education instructor in the development of the program.

78-0006 Stone, E.J.; Solomon, J.
Multidisciplinary patient education. Health Education 9(4): 39, Jul./Aug. 1978.

At the University of New Mexico a course was developed and implemented based on the premise that various health professionals need preservice and inservice training in the theory and application of patient education and multidisciplinary teamwork. The basic philosophy of the course was that the process of patient education is a shared responsiblity and that many health professionals play a role. It is not limited to the doctor or to the nurse.

COMMUNITY HEALTH EDUCATION

78-0007 Sheffield, R.
Community health education: beyond fad to commitment. Annotations Bulletin 51(37): 99-102, Sep. 1, 1977.

Community health education is more than a passing fad at New England Memorial Hospital, Stoneham, MA. It is a firm commitment embodied in a very active and comprehensive program. Approximately 60 courses and seminars, with as many as 10 sessions in each, are presented yearly on more than a dozen subjects. Sixty percent of the courses are taught in the hospital; the rest are given by request in places of business, schools, and churches in the 11 communities served by the hospital.

78-0008 Tones, B.K.
The role of the community health education specialist in the delivery of health care. Health Education Journal 36(4): 106-113, 1977.

This paper seeks to define a "model" role for a community health education specialist having due regard to the dictates of professionalism and to the potential of education and the behavioural sciences for increasing effectiveness in the delivery of health care. It subsequently examines the "goodness of fit" between existing health education services and the "model" role by matching this latter with data from a postal survey of 152 health education officers collected just prior to the reorganization of the NHS in April 1974.

78-0009 Ziff, D.
Community relations: hospitals engage in educational, marketing efforts. Hospitals 52(7): 69-74, Apr. 1, 1978.

SCHOOL HEALTH EDUCATION

78-0010 Conley, J.A.; Jackson, C.G.
Is a mandated comprehensive health education program a guarantee of successful health education? Journal of School Health 48(6): 337-340, Jun. 1978.

This study evaluated the health-knowledge of a selected population of 12th grade students. A random selection of 30% of the total senior population from 7 public high schools was obtained. The Kilander-Leach Health Knowledge test was used. An analysis of variance was performed by sex and by health area. The FLSD multiple range test was utilized where significance was found among groups. The

findings revealed that students' health knowledge was weak; moderate strength was indicated in the area of chronic disease; no significant differences were observed between males and females on the total test; there was significant differences in health knowledge on the total test among the schools.

78-0011 Grosshans, O.R.
Personal behavior change projects. Health Education 8(5): 22-23, Sep./Oct., 1977.

78-0012 Olsen, L.K.; Redican, K.J.
Primary grades curriculum project--innovations in health education. Health Education 9(4): 21-22, Jul./Aug. 1978.

The Primary Grades Curriculum Project was specifically designed for implementation in grades K-3, thereby acting as a companion project to the School Health Curriculum Project (Berkeley Project). It is through the combined efforts of innovative teachers, involved voluntary agencies, and governmental support through the Bureau of Health Education, that the implementation of the Primary Grade Curriculum Project has met with such success initially.

78-0013 Williams, C.L.; Arnold, C.B.; Wynder, E.L.
Primary prevention of chronic disease beginning in childhood. Preventive Medicine 6(2): 344-357, Jun. 1977.

A controlled study is described for chronic disease risk factor identification and intervention among 3,000(of 4,600 eligible) school children, 11 to 14 years of age. Medical screening is followed by return of results to the student participants in a "Health Passport" and is reinforced by a multidimensional health education intervention program which seeks to produce early development of healthy behavior patterns including encouragement of self-responsibility for health. Preliminary data (Williams, C.L. and Wynder, E.L., JAMA 236, 2196-2197[1976] from the first annual screening suggest that the most common risk factors among children, ages 11 to 14 years, are hypercholesterolemia (17% over 180 mg%), obesity (12%), and cigarette smoking (10%). A strategy for follow-up and intervention for high risk children is described.

78-0014 York, P.A.; Barnett, S.E.
Bilingual/bicultural - health education for children of migrant farmworkers. Health Education 8(5): 4-6, Sep./Oct. 1977.

During the preparation for the 1976 farmworker season, the health education component of the Student Health Program for Migrant Farmworkers and Rural Poor (SHP) at the University of Colorado Medical Center (UCMC), in cooperation with the Colorado Department of Education (CDE), the Colorado Department of Health (CDH), and the Colorado Migrant Council (CMC)--all members of the Colorado Migrant and Rural

Coalition--developed a bilingual-bicultural health education program for federally funded Day Care/Head Start Centers and Title I Schools in underserved areas throughout rural Colorado.

SEX EDUCATION

78-0015 Hansen, H.; Stroh, G.; Whitaker, K.
School achievement: risk factor in teenage pregnancies? American Journal of Public Health 68(8): 753-759, Aug. 1978.

A review of live births, spontaneous fetal deaths, and induced abortions in residents of Upstate New York ages 12-17 shows that pregnancy rates increased during the period 1971 through 1974. This increase was attributable to pregnancies ending in induced abortion while live births remained relatively stable. White teenagers had a higher frequency of induced abortions than non-white teenagers, but induced abortions increased more rapidly among non-whites over the four-year period. School achievement as reflected by highest grade completed at the end of pregnancy was related to risk of pregnancy as well as to election of induced abortions. The distribution of pregnancies by age and school grade suggests that an increased risk of pregnancy is associated with below average but also, and unexpectedly, with above average grade attainment. Incongruity of age and school achievement may identify groups of teenage school girls with special needs for preventive programs.

78-0016 McAnarney, E.R.; Adams, B.N.
Development of an adolescent maternity project in Rochester, New York. Public Health Reports 92(2): 154-158, Mar./Apr. 1977.

Health services for pregnant teenagers have not kept pace with the demand, despite a gradual change over recent years in attitudes in the United States toward women who become pregnant out of wedlock. Even in geographic areas with adequate facilities for teenagers, the pregnant adolescent and her boyfriend may find it difficult to enter the health system. Inaccessibility of clinics and financial barriers are two reasons frequently cited for the failure of teenagers to get appropriate medical care. A major challenge then for planners of health programs is to establish accessible, economical, comprehensive facilities that will provide pregnant teenagers with the medical and psychological care they need in one setting. Such programs should teach adolescents about their sexuality and the responsibilities they bear as sexually mature people. The authors describe the development of one such program, the Rochester Adolescent Maternity Project (RAMP), established at the University of Rochester Medical Center in 1969.

78-0017 Price, S.; Golden, J.; Golden, M.; Price, T.; Leff, J.; Heinrich, A.G.; Munford, P.
Training family planning personnel in sex counseling and sex education. Public Health Reports 93(4): 328-334, Jul./Aug. 1978.

A flexible and relatively cost-efficient training model was designed and used in a number of family planning agencies to train staff to patients with sexual problems. Trainees reported that participation in the various training programs had had considerable influence on their current approach to counseling patients with sexual problems. Trainees reported increased comfort and openness about their own sexuality, an increased sensitivity to patients' problems, and the ability to initiate discussions about previously taboo sexual topics, increased knowledge and skill in providing information and counseling, and a desire to continue to practice their newly learned skills and acquire further training.

The availability of reliable forms of birth control has the potential for improving the quality of sexual relationships. However, many patients suffer from a lack of accurate information and poor sexual and interpersonal skills. Many otherwise viable relationships are seriously undermined by sexual problems, and particularly for low-income patients there are few sources of help. In most family planning settings, discussions of birth control are kept separate from discussions of sexuality, and frank discussions of sexual problems and concerns are typically neglected. The findings in this project suggest that family planning physicians, nurses, counselors, educators, and volunteers can be trained in a relatively short time to provide a wide range of sorely needed sex information and counseling to the patients with sexual problems and concerns.

LIFESTYLE

78-0018 Breslow, L.; Somers, A.R.
The lifetime health-monitoring program. New England Journal of Medicine 296(3): 601-607, Jan. 20, 1977.

Current patterns of health care and its financing need to be improved by the incorporation of cost-effective and health-effective preventive measures. As a stimulus for further development, the authors propose a Lifetime Health-Monitoring Program that uses clinical and epidemiologic criteria to identify specific health goals and professional services appropriate for 10 different age groups. During infancy, for example, we recommend seven immunizations, tests to detect anemia, hemorrhagic diseases, phenylketonuria and developmental deficiencies, and routine prophylaxis of gonorrheal ophthalmia. In the age group 40 to 59, tests for hypertension, cervical, mammary, and gastrointestinal cancer, and control of obesity and smoking are in order.

The cost of such preventive measures, which should not be prohibitive, must be covered by health insurance programs, whether based on fee-for-service or capitation. The program suggested, by incorporating prevention into day-to-day care, should strengthen the patient-physician relation.

78-0019 Collin, M.L.

Behaviour modification techniques: their use in individual and community programmes. International Journal of Health Education 20(1): 29-37, 1977.

New Perspectives on the Health of Canadians described the self-inflicted nature of many of the major medical problems facing Canada. Given this understanding it might have been anticipated that a carefully mounted large scale health education programme would lead to a reversal of behaviour-related complaints. However, such programmes have not had a strong record of success, with the possible exception of the recently reported Stanford Three Communities study, which is concerned with decreasing cardiac risk factors by a process of mass persuasion, aimed at teaching specific behavioural skills. In the past, living conditions have changed slowly and appropriate lifestyles have evolved along with changing conditions. Only recently has environmental change occurred so dramatically that living patterns could no longer mutate and develop gradually to keep pace. Hence the demand for behavioural science to assist people to develop new lifestyles which are in synchrony with a rapidly-changing world.

Examination of the literature concerning the application of behaviour modification techniques to specific problems clearly demonstrates the difficulties involved in changing behaviours such as smoking and overeating. Behaviour change related to increasing physical activity shows more promise in that it can be presented positively as a pleasant addition to people's lives. If lifestyle modification and environmental control are going to assume a larger part of the health care system, methods have to be devised to translate the experimental successes with relatively small numbers into powerful programmes for press action.

78-0020 Franklin, B.A.

Motivating and educating adults to exercise. Journal of Physical Education and Recreation 49(6): 13-17, Jun. 1978.

The purposes of this paper are (1) to examine the factors affecting long-term participation in exercise training programs and (2) to present educational and motivational suggestions to the exercise leader or adult fitness program director who is vitally interested in stimulating interest and enthusiasm among program participants.

78-0021 Gellman, D.D.; Lachaine, R.; Law, M.M.

The Canadian approach to health policies and programs. Preventive Medicine 6(2): 265-275, Jun. 1977.

In Canada, national health policies and programs have developed as a result of joint efforts of the federal and provincial governments. A

federal General Health Grant program, starting in 1948, assisted the provinces in upgrading hospital facilities, in training health professionals, in research, and in categorical programs to control such diseases as cancer, tuberculosis, and V.D. A universal program of insurance for hospital care was introduced in 1958 and was followed, 10 years later, by universal insurance to meet the cost of physicians' services. Having taken care of the major "sickness" services, attention is now being turned to prevention, with particular emphasis on programs to improve the physical and social environment and to encourage such personal habits as careful driving, use of seat belts, exercising, not smoking cigarettes, moderation in the use of alcohol and food, and abstaining from using drugs except for medicinal purposes.

78-0022 Haggerty, R.J.
Changing lifestyles to improve health. Preventive Medicine 6(2): 276-289, Jun. 1977.

Lifestyle is the most important modifiable factor influencing health and illness today. It is difficult to stimulate the development of or change to a healthy lifestyle with traditional health education methods. For some problems behavior change may require authoritarian means: "Managerial Prevention" such as enforced speed limits, air bags, taxes, etc. For a few, education through social groups and mass media may be adequate. For other health problems, only supportive medical care will be available for some time to come. For most health problems, a combination of approaches using all methods to change lifestyle and appropriate use of medical care will be necessary. Finally, for some health problems we may decide that they must be endured in order to support values more important than health.

78-0023 Walker, W.J.
Changing United States life-style and declining vascular mortality: cause or coincidence? New England Journal of Medicine 297(3): 163-165, Jul. 21, 1977.

GENERAL HEALTH EDUCATION

78-0024 Fielding, J.E.
Health promotion--some notions in search of a constituency. American Journal of Public Health 67(11): 1082-1085, Nov. 1977.

78-0025 Health Resources Administration

Preparation and practice of community, patient and school health educators. Proceedings of the Workshop on Commonalities and Differences, Feb. 15-17, 1978. U.S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, Bureau of Health Manpower. DHEW Publication No. (HRA) 78-71, Apr. 1978, 72 pp.

In February 1978 a workshop was held to bring together professional health educators from a variety of settings to discuss and analyze the commonalities and differences that exist in the preparation and practice of health educators. Specifically, the purpose of the workshop was to afford an opportunity for participants to exchange views concerning: (1) The parameters and current State-of-the-Art of Community, School and Patient Education; (2) The commonalities and differences in preparation and practice of health educators functioning in these various environmental settings; and (3) The potential for fashioning acceptable guidelines for professional preparation and practice that will include all of the health education settings.

78-0026 Loring, W.C.

Environmental health education: a different orientation. International Journal of Health Education 20(1): 51-56, 1977.

The individual behaviour, group habits and corporate activities that are the keys to environmental prevention are markedly different in character from the personal hygiene and illness behaviours of primary care and patient education. Education for personal care is oriented towards the educatee's own future behaviour and related to the internal processes of his or her physiological organism. It is learning that is aimed both at children and adults. In contrast, in environmental prevention, education is oriented to changing present behaviour related to external stressers and feedbacks. In most programmes this learning is aimed at adults.

78-0027 Modolo, M.A.; Figa-Talamanca, I.

Interaction between consumers and providers of health services: new roles and their implications. International Journal of Health Education 20(1): 41-44, 1977.

78-0028 Rodger, D.L.; Jang, Y.L.

Attitude and value change: health education contrasts in the U.S. and the People's Republic of China. International Journal of Health Education 20(2): 90-97, 1977.

The success of the Chinese in effecting overwhelming change in the health conduct and status of their people has presented an enigma and challenge to change agents throughout the world. This paper attempts to provide a perspective for viewing the Chinese success by

contrasting the targets and approaches of Chinese and western health education. In doing so, a distinction will be drawn in the ideology and philosophic tradition of each approach. Most fundamentally, these distinctions will centre on changes in health conduct through methodologies of attitude change as practiced in the West and value change as conducted in the Chinese case. The societal context which largely determines the behaviour change strategies accepted by a people will be examined as a clue to this difference in approach.

78-0029 Smith, B.I.

An analytical study of selected writings and their relationship to health. Journal of School Health 48(6): 366-370, Jun. 1978.

An identification of the central characteristics and concepts of health has evolved over years of study by individuals and groups within the field of health education. These philosophical discussions about health have been expressed in the investigations and writings of such people and groups as: Jesse F. Williams, Anne Whitney, C. E. Turner, Mable E. Rugen, Delbert Oberteuffer, Howard Hoyman, the Commission on Philosophy for School Health Education, 1962, and many others. This study was designed to build upon the understanding of these fundamental characteristics of health as they are reflected in the writings of philosophical thinkers from a variety of other fields of study. The problem investigated was an analysis of the writings of Rene Dubos, Erich Fromm, Abraham Maslow, Ashley Montagu, Paul Tillich, and Paul Tournier and selected components of their philosophies relating to the basic meaning of health.

RESEARCH AND EVALUATION

78-0030 Lewis, F.M.; Morisky, D.E.; Flynn, B.S.

A test of the construct validity of health locus of control: effects on self-reported compliance for hypertensive patients. Health Education Monographs 6(2): 138-148, Spring 1978.

A test of the construct validity of the Health Locus of Control (HLC) scale is presented within the larger framework of Rotter's social learning theory. Self-reported compliance behavior was predicted to relate to the subject's HLC orientation, value toward health, and level of perceived home assistance. In a sample of ambulatory hypertensive patients, a significant two-way interaction effect was calculated between the perceived level of home assistance and the patient's HLC orientation ($p = .02$). The more internally oriented the patient and the higher the level of perceived home assistance in complying with the prescribed medical regimen, the greater the level of self-reported compliance behavior.

78-0031 O'Rourke, T.W.; Allegrante, J.P.
Multivariate statistical methods--A means to improve research in health education. Journal of School Health 47(9): 550-554, Nov. 1977.

To date, the problem with much of the research in health education has been the absence of sophisticated data handling as reflected in the dearth of studies using multivariate statistical methods. Certainly multivariate statistical methods are not new, nor are they a panacea for increasing knowledge of the complex problems studied in health education. However, given proper application, these methods represent powerful research tools with significant potential for helping to understand health behaviors and, of course, the health education process. To use such tools will undoubtedly expand knowledge and, in turn, raise even more difficult problems that will demand further study. However, to not use them would be inexcusable considering the available technology. It is hoped that this discussion will have helped promote expanded interest and the responsible application of multivariate statistical methods to research problems in health education, thus helping to improve research in the field.

78-0032 Parcel, G.S.; Meyer, M.P.
Development of an instrument to measure children's health locus of control. Health Education Monographs 6(2): 149-159, Spring 1978.

Studies were conducted with children ages 7 to 12 years to develop an instrument to measure children's health locus of control. Findings provide evidence that the Children's Health Locus of Control scale has acceptable levels of reliability, internal consistency, and construct validity. Item analysis and factor analysis were performed to determine item effectiveness and existence of significant subscales. Implications of this research for health education of children are discussed. Links between the theoretical basis for the locus of control construct and a more comprehensive explanation of health behavior are outlined.

78-0033 Sheiham, A.
Evaluating health education programmes. Health Education Journal 37(1): 127-131, 1978.

Health education officers constantly assess the programmes under their control though they may not call the process 'evaluation'. They gauge the rate of progress of a new programme, appraise personnel performance, estimate the effectiveness of a particular technique, look at other programmes and compare the results. This routine day-to-day process may not suffice, particularly now when we are in an era of accountability. As there are no current reviews on evaluation generally available, the authors review the current concepts about evaluation and suggest some guidelines which health education officers could apply.

78-0034 Wallston, B.S.; Wallston, K.A.
Locus of control and health: a review of the literature. Health Education Monographs 6(2): 107-117, Spring 1978.

Locus of control, an individual difference construct from social learning theory, has shown some promise in predicting and explaining specific health-related behaviors. Research is reviewed on the utility of the locus of control construct in understanding smoking reduction, birth control utilization, weight loss, information-seeking, adherence to medication regimens, and other health or sick-role behaviors. Implications for health educators are presented.

78-0035 Wassertheil-Smoller, S.; Bijur, P.; Blaufox, M.D.
An evaluation of the utility of high blood pressure detection fairs. American Journal of Public Health 68(8): 768-770, Aug. 1978.

The contention that high blood pressure detection at health fairs or other "one shot" efforts do not stimulate treatment and control of hypertension; this has been investigated by the follow-up of hypertensives detected in a New York City housing project, and in a suburban location. The data reported address the question of who attends such screens and what happens to the hypertensives detected in terms of the follow-up medical care they seek?

The authors' data indicate that voluntary casual screenings in essentially middle class locations may be of limited value in attracting the young, the black, and the male relative to the target population. Our screens attracted a large proportion of individuals who were already aware of their high blood pressure. Nevertheless, these screens can be useful in getting and keeping individuals under medical care; newly detected hypertensives, those who knew they have it and even some of those under treatment for it.

SMOKING

78-0036 Dale, J.J.
An evaluation of a programme of school health education on smoking. Health Education Journal 37(1): 142-144, 1978.

This paper describes an evaluation of an on-going health education programme regarding cigarette smoking undertaken in certain middle schools in Leeds. Attention was given to the three aspects of knowledge, attitude and behaviour. These were examined by means of a pre and post questionnaire technique. The results indicated a marked improvement in knowledge, a slight improvement in attitude and equivocal changes in behaviour.

78-0037 Heit, P.
Treatment vs. prevention of smoking. Health Education 9(3): 8-9, May/Jun. 1978.

Many educators, researchers, consultants, and community health personnel, as well as concerned citizens groups, have developed approaches and programs to deal with smoking.

There is a common idea in most of these programs--a reliance on prevention. If we are to cope effectively with the school-age smoking problem, a shift in emphasis from prevention to treatment may be necessary. Although smoking education serves an important part in preventing some students from taking up smoking, it seems to do little for the student who is already deep into the tobacco habit. These students need a form of treatment for the problem they now have.

78-0038 Kaplan, G.D.; Cowles, A.
Health locus of control and health value in the prediction of smoking reduction. Health Education Monographs 6(1): 129-137, Spring 1978.

Thirty-five participants in a smoking cessation program met weekly for seven weeks in small groups and then were assigned to one of four follow-up procedures for an additional eight weeks. Information on smoking levels was obtained at the beginning of the program, at the end of the seven-week treatment period, at the end of the two-month follow-up period, and during an additional five-month extended follow-up period. As hypothesized from social learning theory, individuals who held internally-oriented health locus of control beliefs and who valued health highly were most successful in achieving and maintaining changes in their smoking behavior. These results are discussed in terms of their implications for the problem of maintenance of behavior changes achieved by smoking cessation programs.

78-0039 Mills, D.; Ewy, B.M.; Dizon, J.
Smoking cessation in high school. Health Education 9(3): 5-7, May/Jun. 1978.

The authors believe that smoking cessation programs for senior high students is an area where positive behavioral change can be demonstrated through a sound health education program in a relatively short span of time. Senior high students no longer unconsciously espouse the social desirability of smoking. In fact, there is a growing number of militant nonsmokers and ex-smokers putting social pressure on peers not to smoke.

The situation at the junior high level is less clear. The fact that faculty are taking an interest in actually trying to change their students' smoking behavior is encouraging, but it is unknown whether smoking cessation programs at this level can be successful. Overcoming the great peer pressure that is present at this age level seems

the biggest barrier to a successful program.

78-0040 Thompson, E.L.
Smoking education programs 1960-1976. American Journal of Public Health 68(3): 250-257, Mar. 1978.

This paper is a review of published reports, in English, of educational programs designed to change smoking behavior. Attempts to change the smoking behavior of young people have included anti-smoking campaigns, youth-to-youth programs, and a variety of message themes and teaching methods. Instruction has been presented both by teachers who were committed or persuasive and by teachers who were neutral or presented both sides of the issue. Didactic teaching, group discussion, individual study, peer instruction, and mass media have been employed. Health effects of smoking, both short-and long-term effects, have been emphasized. Most methods used with youth have shown little success. Studies of other methods have produced contradictory results.

Educational programs for adults have included large scale anti-smoking campaigns, smoking cessation clinics, and a variety of more specific withdrawal methods. These methods have included individual counseling, emotional role playing, aversive conditioning, desensitization, and specific techniques to reduce the likelihood that smoking will occur in situations previously associated with smoking. Some of these techniques have produced poor results while studies of other methods have shown inconsistent results. The two methods showing the most promise are individual counseling and smoking withdrawal clinics.

78-0041 Zimmerman, M.W.
No smoking, please! Hospitals 52(15): 183-186, Aug. 1, 1978.

In an effort to be responsive to the needs of its nonsmoking patients, Louis A. Weiss Memorial Hospital, Chicago, established a no-smoking patient care floor. The program has been enthusiastically accepted by patients, the public, and hospital employees. In fact, the no-smoking unit has consistently had the highest occupancy rate of any medical-surgical unit in the hospital.

SELF CARE

78-0042 Grant, R.H.
Family and self-help education in isolated rural communities. Health Education Monographs 5(2): 145-160, Summer 1977.

Family and self-help education courses were developed to promote better personal health through more appropriate utilization of health services in underserved rural areas. Instructional target

areas were health problems of young children and the elderly and emergency situations. Objectives and evaluation criteria were formulated after consultation with representatives of participating communities and expert advisors. Community advisory committees were identified or created to supervise program development and implementation. Local instructors were utilized and developed specific course content. An evaluation of one course showed that knowledge and decision-making skills significantly improved for participants.

78-0043 Green, L.W.; Welin, S.H.; Schauffler, H.H.; Avery, C.H.
Research and demonstration issues in self-care: Measuring the decline of medicocentrism. Health Education Monographs 5(2): 161-189, Summer 1977.

Emergence of consumer health self-care is a reflection of the increased commitment of health professionals to patient education, growing consumer awareness that they are capable of sophisticated self-help, and a variety of social, economic and technological currents. These currents are reviewed and a survey of existing medical self-care programs is summarized. The attempts and potentials to evaluate these programs are critically examined.

A number of important research and demonstration issues are raised including the determination of behavioral outcomes, technical limits, and manpower implications. A federal program of replicative studies on such issues would provide substantive knowledge in the self-care field, generalizable to the larger field of health education, but the hazards of undermining the voluntaristic and non-establishment character of the programs must be considered in designing evaluative studies.

78-0044 Hentges, K.
Health activation education for self-care. Health Education 9(4): 31-32, Jul./Aug. 1978.

Health activation assumes that through knowledge and techniques people will become aware of what makes up health, take on greater responsibility for their own health, use the health care system properly, and improve the patient-provider relationship with this new awareness. The self-care concept is not new; it is a return to beliefs once held widely.

78-0045 Levin, L.S.
Forces and issues in the revival of interest in self-care: impetus for redirection in health. Health Education Monographs 5(2): 115-120, Summer 1977.

Most health and medical care is provided by families and individuals to themselves. Self-care has become a salient public issue because of the emergence of chronic diseases as leading causes of death and disability; a new awareness of the limitations of conventional medical care; and social changes which emphasize greater personal control. Challenges arise in definition of professional roles in relation to organized self-care efforts, economic implications, and development of appropriate social policies. A negative potential exists for exploitation by interests which would limit movements for more equitable and higher quality health services, but should not obscure the positive potential for a strengthened partnership in health between the lay and professional worlds.

78-0046 Matheson, G.W.
A medical self-help training program...for rural communities. Health Education 8(5): 2-3, Sep./Oct. 1977.

78-0047 Milio, N.
Self-care in urban settings. Health Education Monographs 5(2): 136-144, Summer 1977.

A variety of indicators favors the development of self-care systems for inner-city populations. This cannot be conceived as an isolated individual or a family enterprise. To be effective, self-care must be a community concept. This type of system requires (1) an information base; (2) an organized method of dissemination in a community; (3) support structures; and (4) an evaluation subsystem. A community-oriented system would be an alternative and a complement to formal health services; individuals and families would manage common health problems, but would have ready access to formal services through community organizations. Links must also be provided between personal self-care and other forms of community development.

78-0048 Pratt, L.
Changes in health care ideology in relation to self-care by families. Health Education Monographs 5(2): 121-135, Summer 1977.

Health care is shifting from a professional-independent to a business-bureaucratic orientation. Both professional and business ideology have been unfavorable to the development of self-care and a strong health care role for families. But business ideology contains more loopholes for the emergence of a higher level of family self-care activity. The shift forces consumers to take a cautious posture in the marketplace, encouraging active management of their own health

care. However, families will obtain government support for their self-care activities and a policy-influential role in health system governance only through organized political action.

MISCELLANEOUS

78-0049 Bennett, B.E.
A model for teaching health education skills. Health Education 8(5): 15-18, Sep./Oct. 1977.

Health education skills are often neglected and ignored in medical education, because it has been incorrectly assumed that patient teaching is a skill automatically acquired by health practitioners. This article presents a comprehensive approach to teaching and incorporating health education knowledge and skills in a primary care practitioner program.

78-0050 Cooper, T.
Present HEW policies in primary prevention. Preventive Medicine 6(2): 198-208, Jun. 1977.

Federal preventive health policies are predicated on factors and conditions deemed likely to pertain to the health field for some time to come: cost escalation, the uncertainty that discovery will yield epochal advances in diagnosis and curative medicine, and the growing awareness of relatively unused paths toward disease and injury prevention along both medical and nonmedical approaches. Four broad and interrelated elements of a preventive health strategy have been identified: health education, nutrition, child health, and the environment. To a large extent, the emphasis in each of these areas is on efforts to modify individual and institutional behavior, to increase awareness of both personal and community responsibility for the preservation and maintenance of health, and to interrupt processes and behavior that jeopardize health. Federal policy aims at supporting preventive health as the most promising approach toward significant improvement in the health of the American people.

78-0051 Lee, P.R.; Franks, P.E.
Primary prevention and the executive branch of the Federal government. Preventive Medicine 6(2): 209-226, Jun. 1977.

The scope and nature of primary prevention programs conducted or supported by the Executive branch of the Federal government are examined using a broad definition of primary prevention and a new conceptual framework, the Integrative Health Strategy, as benchmarks for analysis. Primary prevention is defined as "promoting health and averting the occurrence of illness, injury, and disease." The Integrative Health Strategy, which has been developed as a tool to assess the wide range of policies and programs that impact health, categorizes interventions into four broad areas: health promotion,

health protection, health care, and health research. Efforts in primary prevention at the Executive branch level clearly crosscut these areas. In examining programmatic emphases in primary prevention, four widely available sources were used: The Budget of the United States Government, Fiscal Year 1976 and special analyses of health expenditures by the Office of Management and Budget; the 1976/77 United States Government Manual; and special studies of family planning, air and water pollution, and nutrition programs. Federal outlays for preventive programs may be as low as $900 million or higher than $7 billion depending upon the definition of prevention and the designation of programs as preventive in nature by various analysts.

78-0052 McNeil, J.; Pesznecker, B.L.
Keeping people well despite life change crises. Public Health Reports 92(4): 343-348, Jul./Aug. 1977.

Too much change, too suddenly, and within too short a period can precipitate deleterious physical and emotional reactions in human beings, according to Toffler. Yet there are people who, in spite of many life changes, do not, as a result, experience physical or emotional disturbances. Do these people possess certain attributes that help them withstand the pressures of many life changes? The research reported here was focused on the selected factors that might help a person offset the impact of the rapidly increasing changes that characterize our life today. The results suggest the need for an expanded and creative role for community health workers, who are constantly in contact with people experiencing life crises because they have to face too much change in too short a period.